STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEARDSLEY HOUSE	27833 CR 24 ELKHART, IN46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: June 13, 14, 15, 16, 2011 Facility number: 004353 Provider number: 004353 AIM number: N/A Survey team: Carol Miller, RN TC Honey Kuhn, RN Census bed type: Residential: 22 Total: 22 Census payor type: Other: 22 Total: 22 Sample: 7 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed 6/23/11 by Jennie Bartelt, RN.	R0000	**Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by this facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0006	(f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.			
	Based on observations, record review and interviews, the facility failed to ensure discharge of a resident requiring 24-hour per day comprehensive nursing care related to wandering, incontinence, and infection control for 1 of 1 resident reviewed related to comprehensive nursing care needs in a sample of 7. (Resident #22) Finding includes: The record of Resident #22 was reviewed on 06/13/11 at 10:00 a.m. Resident #22 was admitted to the facility on 11/07/08 with diagnoses including, but not limited	R0006	**R006 Beardsley House issued an involuntary discharge to Resident #22 as she is a danger to herself and others with uncontrolled diarrhea, causing a risk for infecting others, and a risk to her overall health. Resident #22's daughter, who is also her medical power of attorney, has refused any type of testing or treatment. She has also refused a third party provider. Beardsley House has sent Resident #22 to the emergency room so that testing could be completed in order that proper treatment is obtained. The daughter refused to let the**	07/31/2011

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	to: dementia, hypertension, osteoporosis, recurrent UTI's (urinary tract infections) and anxiety. Review of lab results in the chart indicated: "Microbiology Procedure: ...Collected 09/09/10 Source: Feces Final Report: Positive for Clostridium Difficile Antigen Positive for Toxin A/B...Notify Infection Control." There were no other lab reports on feces specimens in the record. Review of Resident Services Notes for Resident #22 indicated the following dated, untimed entries: "08/05/10 Staff reported 3 separate episodes of diarrhea c (with) chronic hx (history) of same r/t (related/to) ATB (antibiotic) use for UTI's (urinary tract infections)." "08/06/10 Called (physician's name) cell requesting order for C-diff culture for stools..." "08/10/10 ...was + (positive) for C-diff. Flagyl et (and) Urocid Rx (antibiotics) OK'd..." "08/23/10 Resident was found to have bright red, mucousy stools today..." "09/01/10 Spoke c family...resident will		**hospital do anything with her, and sent her back. A second attempt to discharge to the hospital was made, and the daughter finally agreed to allow treatment for the diarrhea. Testing showed that she was negative for C. Diff. Her lab values were all within normal limits except for being slightly anemic. The hospital ordered a medication and started the treatment, and sent the drug in oral form back with the resident to Beardsley House. Since this resident has had a history of diarrhea in the past, it is thought that she may be having a side effect of Aricept, and the attending physician is considering discontinuing this medication. A plan is in place to contain the loose stool which includes having her wear one piece clothing. The Corporate Medical Director visited the community on 7/15/11 and provided a consultation regarding her condition and spoke with the daughter regarding the problems in dealing with this chronic condition. No other residents were found to be affected. A resident who demonstrates uncontrolled diarrhea will have a physician ordered set of lab tests to rule out an infectious process. The facility will notify the Regional**	

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	eat meals in room c (brand name) underpads and (brand name) liners inside briefs." "09/02/10 ...decision was made yesterday to have resident eat meals in her room r/t dumping syndrome et increase diarrhea when eating in dining room. Explained to daughters (2 names listed) that it was an infection control issue when feces is on chair and floor in public dining room area, but they want resident to remain in dining room for meals. Care plan conference scheduled..." "09/11/10 Resident lab test confirmed positive for clostridium difficile antigen and toxin A/B. Notified WD (Wellness Director: RN)." "09/15/11 10 a.m. Spoke c daughter/POA (Power of Attorney) (name) today residents skin is red and warm to touch-daughter states 'keep her safe and comfortable, no hospital, no Tx (treatment) for infection'..." "09/18/10 Another resident stated this resident was found in her room late last night attempting to climb into bed with her..." "09/19/10 9:00 a.m. .Explosive diarrhea down legs and onto clothing..." "12/23/10 Resident found sitting in hallway..." "01/11/11 10:00 a.m. Resident found c		**Director of Operations and/or the Regional Director of Quality and Care Management of a resident with the presence of a condition that could pose a danger to him/herself and/or others. A plan will be put in place with the staff, resident, if able, and responsible party to address the situation. If a solution is not effective, the resident will be discharged to the appropriate setting. Residents with a change in condition will be discussed during the stand up meeting and a plan will be formulated for physician and responsible party notification of the need for further follow up. A licensed nurse will address the condition with the attending physician and obtain the appropriate orders. The Residence Director will monitor residents with change of condition that could endanger themselves or others and ensure that the appropriate interventions have been implemented. This will continue as an ongoing quality assurance process.**	

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	pants and briefs pulled down and was handling own feces and eating it..." "05/02/11 Resident found wandering in hallway with pants and briefs around ankles, tried to defecate on chair in hallway..." While accompanied by the RD (Resident Director), during the environmental tour, on 06/14/11 between 9:00 and 9:45 a.m., the carpet in the hallway outside of apartment (number) was observed to have seven areas ranging in dime to half-dollar size of dark unidentifiable matter near a chair. The RD indicated the chair was for anyone's use and the areas on the carpet were from Resident #22 defecating on or near the chair. The RD was uncertain how long the areas had been there. Interview with the WD (Wellness Director: RN) on 06/14/11 at 8:30 a.m. indicated Resident #22 was demented and incontinent. The WD indicated the resident had been receiving Hospice services. The WD was interviewed in regard to amount of time spent with the resident by Hospice. The WD indicated the Hospice services were initiated on 05/28/10 and discontinued on 01/24/11. The hospice services consisted of a bathing aide 2 times a week for 1 hour and a nurses visit 1 time a week for 1 hour.			

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The WD indicated the family refused to have the resident retested for C-diff. When queried, the WD indicated she could not require the test if the family did not want it done. The WD indicated the facility had addressed issues with corporate in regard to the resident defecating in common areas; however, the facility was instructed they could not discharge the resident. The WD indicated the facility had identified Resident #22 was an infection control risk but were unable to provide continued monitoring to prevent the resident from defecating throughout the common areas.

During interview, the WD indicated the public restrooms were normally kept locked due to the wandering of Resident #22.

The WD was interviewed again, on 06/16/11 at 9:30 a.m., in regards to Infection Control and if the facility had a Policy and Procedure manual or guidelines to refer to. The WD was uncertain but thought the information could be found in the corporate resource guide. The WD indicated no inservices were completed with staff following the diagnosis of C-diff for Resident #22.

PSA #2 (Personnel Service Assistant) was

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	interviewed on 06/16/11 at 9:00 a.m. PSA #2 indicated Resident #22 is known to have a long term diagnosis of C-diff with recurring bouts of loose feces. PSA #2 indicated it was very difficult to monitor Resident #22 due to the resident's history of wandering. PSA #2 indicated Resident #22's care needs are greater due to hygiene issues related to incontinence. The Housekeeper/Activity Director, Employee #8, was interviewed on 06/16/11 at 9:10 a.m. Employee #8 indicated Resident #22's environmental care needs require more time than staff can address due to incontinence issues. Review of the Admission Packet included a copy of the "State of Indiana Residency Agreement (Private Pay) 02/2008" packet which indicated: "SECTION II-RIGHTS AND RESPONSIBILITIES... 2. SHARED RESPONSIBILITY...The parties will also identify the resident's needs that will not be met by the Residence; assess the potential harm resulting from those unmet needs or preferences; and identify the agreed upon courses of action to address the unmet needs and preferences and each party's responsibility."			

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	"SECTION IV-TERMINATION OF THE RESIDENCY AGREEMENT..... 2. BY THE RESIDENCE. The Residence may terminate this Agreement upon thirty (30) days written notice to You for one or more of the following reasons:... b. Your safety or the safety of others in the Residence is endangered; c. Your health or the health of others in the Residence would otherwise be endangered;...." The Residence may terminate this Agreement with less than thirty (30) days notice in the following circumstances:... b. The health or safety of individuals in the Residence would otherwise endangered."			
R0116	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to have on the premises a criminal background check for 1 employee. This deficiency affected 1 of 5 employees whose criminal background	R0116	**R 116 Beardsley House will complete a criminal background check for new applicants. In cases where there is a negative criminal history, Human Resources will be contacted promptly prior to**	07/31/2011

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	checks were reviewed (Resident Director). Findings Include: On 6/15/11 at 10:00 a.m., the employee records were reviewed and indicated the Resident Director (RD) was hired on 4/13/11. There was no documentation that a criminal background check was done for the RD. On 6/16/11 at 11:15 a.m., an interview with RD in regard to his criminal background check indicated when he was hired, a criminal back ground check was done. The Resident Director indicated he had called the Corporate office and Human Resources and was still unable to obtain his criminal back ground check.		**hire. The policy reads that an offer of employment is contingent on a negative criminal background check. Documentation of the background check will be maintained in the personnel record. The Regional Director of Operations or designee will ensure that the Residence Directors will be trained regarding obtaining background checks. The Regional Director of Operations and/or Regional Director of Quality and Care Management will review a sampling of new employee files at least every 30-45 days during house visits to ensure that the background check was completed and if a negative criminal history is discovered, that it has been referred to Human Resources.** **R0116-7/29/11 Addendum** **The Regional team member will review at least** **2 new employee files unless there are no new employees hired since the last house visit.**	

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R0120	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review the facility failed to ensure 1 employee had the annual 3 hours of dementia training. This deficiency affected 1 of 2 employees	R0120	**R 120 QMA #5 is no longer employed by Beardsley House. No other staff members were identified without the required training. Beardsley House will**	07/31/2011

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	in a sample of 2 who had been employed longer than 1 year and did not have the annual 3 hours of dementia training (QMA #5). Findings include: On 6/15/11 at 10:00 a.m., the Employee Records were reviewed for two employees and indicated QMA #5's date of hire was 4/14/08. On 6/15/11 at 10:30 a.m., the annual mandatory inservices were reviewed for 2010 and 2011 and there was no documentation found to indicate QMA #5 received her annual dementia training. On 6/16/11 at 11:00 a.m., the Wellness Director was interviewed in regard to the 3 hours of the annual dementia training. The Wellness Director indicated she had been employed since August 2010 and was unable to locate 2010 thru 2011 dementia training inservices documentation and she currently has a dementia inservice scheduled for 8/2011 .		**schedule the 3hr annual dementia training on a routine basis and ensure that each staff member attends. The staff will sign in on an attendance record in order to provide proof of training. The Wellness Director or designee will plan an inservice schedule in advance, and inform the staff of the schedule. The Residence Director will monitor the attendance records and identify those staff members who have not completed the required training and ensure that the training is scheduled for them.**	

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R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure a second step	R0121	**R 121 The Residence Director received a 2 step Mantoux test. No other staff were**	07/31/2011

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	tuberculosis test was administered to 1 new employee. This deficiency affected 1 of 5 new employees who were reviewed for tuberculosis testing (Resident Director). Findings include: On 6/15/11 at 10:00 a.m., the employee files were reviewed and indicated the Resident Director had started work on 4/13/11. The Resident Director had received a first step tuberculosis (TB) test on 4/16/11 and there was no documentation that indicated a second step TB had been given. On 6/16/11 at 10:30 a.m., the undated policy for TB Tests for Staff was received from the Wellness Director and indicated "1. All employees who do not have a documented history of a positive TB test must have a Mantoux method TB test upon employment... 3. The two-step process is recommended for the baseline (first screening)...." On 6/16/11 at 10:45 a.m., the Wellness Director was interviewed in regard to the Resident Director's second step tuberculosis test, and she indicated the second step TB test got overlooked and did not get done.		**identified without the required TB skin testing. The Wellness Director or licensed nurse will ensure that new staff members receive a 2 step Mantoux test. The first step must be read prior to resident contact. The Residence Director will monitor the personnel records of new staff members to ensure that the 2 step Mantoux testing has been completed. The Regional Director of Quality and Care Management will complete a check of new staff personnel folders for evidence of completion of Mantoux testing at each house visit every 30-45 days for 3 visits. R0121-7/29/11 Addendum The facility will have a notebook with each month of the year separated by a tab in which the employee TB records are filed so that at the beginning of each month, the employee who has a yearly Mantoux test due will receive it. As part of the pre-employment paperwork, there is now a Mantoux testing record included so that a new employee will receive the Mantoux prior to starting work.**	

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R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observations and interviews, the facility failed to maintain a clean environment in a state of good repair as evidenced by carpets soiled with general debris and unknown matter; soiled and scuffed walls and interior doors; chipped, gouged and scuffed interior doorframes; 4 of 4 windowed doors to the facility courtyard with filmy appearance and fingerprints; chipped, soiled, and scuffed wall paint; and bent window blinds at 2 of 4 windows next to exit doors. This deficiency had the potential to affect 22 of 22 residents who reside in the facility. Findings include: The environmental tour of the facility was on 06/14/11, between 8:45 and 9:45 a.m., while accompanied by the RD (Resident Director who was hired 04/13/11. General Observations occurred throughout the survey, between 06/13/11 and 06/16/11. The facility is made up of four halls which form a square with a courtyard in the middle. Exit doors to the courtyard are located midway between each hall. The	R0144	**R 144** **The Regional Maintenance Tech has contracted painting and repair services to address the areas that are in need of repair and repainting with work commencing on 7/31/11. ChemDry has been scheduled for 7/21 to complete carpet cleaning.** **No residents were directly affected.** **Staff will be educated to report identified areas in need of repair or painting to the Residence Director and/or Maintenance Tech. It will be the responsibility of the Residence Director to ensure that the work is completed in a timely manner.** **The Residence Director will be educated regarding the use of an environmental checklist for identifying the need for painting or repairs to the facility physical plant,** **The checklist will be completed**	08/31/2011

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	South hall opens onto the common areas of lounge, activity room, dining room, offices and the main entrance. 4 other exit doors are located at the corners of the other 3 halls. 1. The following observations were made: Baseboard was observed to be gouged, chipped and scuffed on the West side of the West hall. Baseboards between rooms 104 and 106 on the West side of the East hall were observed to be scuffed and chipped. Baseboard was observed to be gouged, chipped and scuffed on both sides of the courtyard door on the North hall. 2. Scuffed and soiled interior room doors: Laundry door Housekeeping room door Twenty-three apartment doors: 101 105 106 108 109 110 112 115 116 117 121 122 123		**weekly x1 month, then monthly thereafter as a routine QA process.** **The Regional Director of Operations and/or the Regional Director of Quality and Care Management will complete a walk through during routine house visits at least every 30-45 days to ensure that the facility is in a state of good repair.** **Completion Date 8/31/11**	

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	126 129 130 131 132 133 134 137 136 138 3. Chipped, soiled and scuffed wall paint: West side of West hall from the South end to beyond Apartment 137. South hall between laundry room doors. Walls around Fire Doors on West hall. West side of East hallway between apartments 104-106. East side of West hall between apartments 128 and 130. Outside walls by apartments: 114, 128, 130, 132, 136, and 138. 4. Windows: West hallway window next to the exterior exit door was observed to contain a large amount of dust and some debris on the windowsill. The blinds were bent out of			

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	shape, resulting in a disheveled appearance. West hallway window blinds next to exit door to the courtyard were observed to be bent out of shape, resulting in a disheveled appearance. Windowpanes in all four courtyard exit doors were observed to have fingerprints and a foggy/hazy appearance. 5. All four carpeted hallways were observed on 06/13/11 and 06/14/11 to have general debris of dirt, leaves, and small pieces of papers. 6. Areas of discoloration on carpets were observed during the environmental tour: A large irregular area approximately 30" X 18" in the hall at the entrance to the dining room. Two round areas approximately 18" in diameter in the TV lounge. A large loop configuration, measuring approximately 3 1/2 yards in length and 1 1/2 " in width outside the medication room. Seven areas ranging in dime to half-dollar size of dark matter around a chair near			

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	Apartment #135. 7. The wall paper on the East of the North hall was observed to have what appeared as dried glue extending approximately 18 feet vertically on a wallpaper seam. The area was approximately 4 feet up from the baseboard and was noted to be stapled along the seam. The RD was interviewed during the tour. The RD indicated the areas on the carpet were from a resident defecating. The RD was uncertain how long the areas had been there. The RD indicated the facility does not have an extractor in working order to address heavily soiled areas. The RD indicated the facility had an extractor however, the extractor had been broken since prior to the RD's employment. The RD indicated the facility would need to take the facility bus from Elkhart, Indiana, to another corporate facility in South Bend, Indiana, to borrow their extractor. The RD indicated the facility had a part time maintenance employee who was allotted 5 hours for 3 days per week (15 hours weekly) to attend to the facility's maintenance needs. Housekeeper/Activity Director, Employee #8, was interviewed on 06/16/11 at 9:10			

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	a.m., Employee #8 works Monday through Friday, 4 hours a day. Employee #8 is the Activity Director for 2 hours daily and the only Housekeeper for 2 hours daily. Employee #8 indicated she is allowed 25 minutes to "deep clean" a resident's room and 10 minutes to lightly dust and straighten rooms. Employee #8 indicated she was given a printed sheet of instructions for cleaning. Employee #8 indicated bleach cannot be used in the facility without permission of the RD.			
R0145	(b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation and interview, the facility failed to ensure a lock on the storage compartment of the housekeeping cart was in proper working order, resulting in unsecured cleaning chemicals and solutions located in the storage compartment, and an extraxtor was in good repair. This deficiency had the potential to affect 22 of 22 residents who reside in the facility. Findings include: Employee #8, Housekeeper/Activity Director, who was hired 02/15/10, was interviewed on 06/16/11 at 9:10 a.m.	R0145	**R 145 The housekeeping cart will have a locked cabinet in order to secure cleaning chemicals. The new locking cabinet was obtained on 7/18/11 and has been mounted. The staff will be educated to lock the cabinet so that confused residents cannot walk off with cleaning chemicals. The Residence Director or designee will check that the cabinet is locked when the cart is in use or in the housekeeping room once on day shift and once on evening shift 3 days/wk x 2 weeks, then 2 days per week x 2 weeks, then once weekly x 2 weeks,**	07/31/2011

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	Employee #8 works Monday through Friday, 4 hours a day. Employee #8 is the Activity Director for 2 hours and the only Housekeeper for 2 hours for Monday through Friday. Employee #8 indicated the housekeeping cart storage compartment, and the lock was observed to be broken, and the key to the lock was rusty. The Housekeeper indicated she had requested the lock be fixed since she was employed, and it had not yet been done. The Housekeeper indicated when she is on the unit cleaning, she faces the side of the cart with the broken compartment door against the wall to ensure residents do not have access to any cleaning solutions she is not using during her cleaning. Employee #8 was queried in regards to the extractor used for heavily soiled carpets. Employee #8 indicated the extractor had worked fine, but prior to the employment of the current RD (Resident Director: Administrator), who was hired 04/13/11, it had been left in the courtyard for over a month during inclement weather. The extractor had not worked since. The RD, interviewed on 06/14/11 during the environmental tour, indicated the facility had an extractor to address heavily		**then monthly as an ongoing QA process.** **R0145-7/29/11 Addendum** **As part of the process of checking the housekeeping cart, verification will be made that the lock is functioning correctly.**	

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	soiled areas of carpeting; however, the extractor had been broken since prior to the RD's employment. The RD indicated the facility would need to take the facility bus from Elkhart, Indiana, to another corporate facility in South Bend, Indiana, to borrow their extractor. The RD, interviewed on 06/16/11 at 11:10 a.m., indicated being unaware the compartment door on the housekeeping cart was broken.			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interviews and record reviews, the facility failed to ensure the Service Plans were signed by the resident or family member. This deficiency affected 3 of 7 sampled residents whose Service Plans were reviewed (Residents #3, #21, #22). Findings include:	R0217	**R 217 Residents will have a current Service Assessment and Service Plan in place. It will be discussed with the resident and/or responsible party, and a signature will be obtained on the document, indicating that they have participated in and reviewed the plan. Current Service Assessments and Service**	07/31/2011

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	1. The clinical record of Resident #21 was reviewed on 6/13/11 at 1:15 p.m., and indicated the resident was admitted to the facility on 11/21/09 with diagnosis including, but not limited to, diabetes and hypothyroidism. The Assessment and Negotiated Service Plan Summary dated 1/7/11, was unsigned. On 6/13/11 at 2:15 p.m., the Resident Director was interviewed in regard to the unsigned Service Plan for Resident #21. The Resident Director indicated the Service Plan was unsigned, and the resident's family was unable to sign the Service Plan, because they lived out of state. 2. The clinical record of Resident #3 was reviewed on 06/13/11 at 10:30 a.m. Resident #3 was admitted to the facility on 07/02/10 with diagnoses including, but not limited to, diabetes, morbid obesity, hypertension, and gout. The "Assessment and Negotiated Service Plan Summary", dated 09/27/10, was unsigned. The "Assessment and Negotiated Service Plan Summary", dated 04/04/11 was		**Plans of Residents #3, #21, #22 will be reviewed to ensure that the information is current. The Residence Director and/or licensed nurse will meet with the resident and/or responsible party and secure the appropriate signatures. The Residence Director and/or a licensed nurse will review the Service Assessments and Service Plans of the current residents will be review to ensure that signatures are present. The Residence Director and/or licensed nurse will ensure that the signatures are obtained as soon as a new Service Assessment and Service Plan is formulated. The Regional Director of Quality and Care Management will review a sampling of Service Assessments and Service Plans to ensure that there are signatures present during routine house visits every 30-45 days.** **R0217-7/29/11 Addendum** **If the resident is unable to sign the service plan, the responsible party will be contacted to come into the facility to discuss the plan and sign it. If the responsible party lives out of the area, and is unable to come into the facility, the plan will be discussed by telephone, and noted as such on the service plan. A copy of**	

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	unsigned. 3. The clinical record of Resident #22 was reviewed on 06/13/11 at 10:00 a.m. Resident #22 was admitted to the facility on 11/07/08 with diagnoses including, but not limited to: dementia, hypertension, osteoporosis, recurrent UTI's (urinary tract infections) and anxiety. The most recent "Assessment and Negotiated Service Plan Summary", dated 01/12/11, was unsigned. The WD (Wellness Director: RN) was interviewed on 06/14/11 at 8:30 a.m. The WD indicated the Service Plans should have been signed by the resident and/or the responsible party. Review of the a corporate Policy and Procedure, provided by the WD on 06/14/11 at 11:00 a.m., titled, "NEGOTIATED SERVICE PLANS: 6/2008", indicated: 1. The Residence Director is responsible for ensuring that all residents have accurate, current, and signed negotiated Service Plans...."		**the plan will be sent by mail with a request to sign the back page and return it in an enclosed self-addressed envelope.**	

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R0246	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure the Qualified Medication Aides (QMA's) obtained permission from the Wellness Director each time they administrated an as needed medication to 1 resident. This deficiency affected 1 of 1 resident reviewed related to administration of PRN medication in a sample of 7. (Resident #25). Findings include: The closed clinical record of Resident #25 was reviewed on 6/14/11 at 9:30 a.m., and indicated a diagnoses including, but not limited to , adenocarcenoma of the lung. The Physician's Order Sheet dated 2/2011 indicated an order for OxyContin 15 milligrams (mg) 1 to 2 tablets every 4 hours prn (as needed) for pain. The Medication Administration Record (MAR) for 2/2011 indicated between 2/1 and 2/14/11 the medication OxyContin	R0246	**R 246** **Beardsley House will ensure that QMAs will obtain permission from a licensed nurse to administer PRN medications and document this permission in the medical record.** **Resident #25 passed away under Hospice care.** **QMAs will be re-educated regarding the Scope of QMA practice. The procedure for obtaining permission to administer PRN medications will be emphasized.** **The Residence Director and/or licensed nurse will check the Medication Administration Record weekly x 4 weeks, then monthly to ensure that PRN medications are given with documented permission from a licensed nurse.** **The Regional Director of**	07/31/2011

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	(for pain) had been administered 14 times by QMA #5 and #6. There was no documentation in Resident # 25's Nurses notes between 2/1 and 2/14/2011, to indicated QMA #5 and #6 had received previous permission from the Wellness Director to administer the prn OxyContin. On 6/14/11 at 11:00 a.m., the Wellness Director was interviewed in regard to the lack of notification prior to the administration of the prn medication OxyContin by the 2 QMA's. The Wellness Director indicated she had not been notified by QMA #5 and #6 each time they had administered the as need OxyContin to Resident #25. The most current undated policy for Medication Administration received on 6/15/11 at 9:00 a.m., from the Wellness Director and indicated "...9. For all PRN medications, the Qualified Medication Aide MUST contact the nurse prior to giving the medication...Document the contact with and authorization given by the nurse in the Resident Service Notes."		**Quality and Care Management will review the Medication Administration Record for appropriate PRN documentation during routine house visits every 30-45 days.**	
R0271	(d) All modified diets shall be prescribed by the attending physician. Based on interviews, observation and	R0271	**R 271**	07/31/2011

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	record review the facility failed to ensure a pureed diet recipe was followed for a resident who had a Physician order for a modified diet. This deficiency affected 1 of 1 resident who received a modified diet in a sample of 7 (Resident #21). Finding include: On 6/13/11 at 11:55 a.m., the Dietary Manager (DM) was observed to mix together in a blender 1 smoked sausage, 1/3 cup broth, 2 tablespoons of thick and easy and 1 cup of cauliflower. On 6/13/11 at 12:00 p.m., the pureed basic meat recipe was reviewed and indicated mix together 2 ounces of meat, 1/3 cup broth and 2 tablespoons of thick and easy. On 6/13/11 at 12:00 p.m., the DM was interviewed in regard the pureed meat recipe not followed as recipe. The Dietary Manager indicated her blender did not puree to the correct consistency and that is why she added the cauliflower to the recipe. The clinical record of Resident #21 was reviewed on 6/13/11 at 1:15 p.m. A physician's order, dated 6/8/11, indicated the resident was to receive a pureed diet. On 6/14/11 at 1:50 p.m., at the daily		**Beardsley House will ensure that the cooks follow the recipe for a pureed diet.** **No other residents were affected.** **The Corporate Director of Dining Services, who is a Dietician, visited Beardsley House on 6/30/11 and reviewed kitchen practices.** **She educated the Dining Services Coordinator regarding preparation of diets using the recipes.** **The Residence Director and/or licensed nurse will observe preparation of an altered diet once weekly x 1 month, then monthly thereafter as a routine QA process.** **The Corporate Director of Dining Services will review preparation of altered diets during routine house visits on a semi-annual basis.**	

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	conference the Wellness Director was interviewed in regard to the recipe for pureed meat not followed and she indicated Resident #21 family have requested they did not want the different foods pureed together.			
R0329	(d) After July 1, 1984, any person who has not completed an activities director course approved by the division shall receive consultation until the person has completed such a course. Consultation shall be provided by: (1) a recreation therapist; (2) an occupational therapist or occupational therapist assistant; or (3) a person who has completed a division approved course and has two (2) years of experience.			
	Based on record and interviews, the facility failed to ensure the activity staff member had an approved credential or consultant. This deficiency had the potential to affect 22 of 22 residents in the facility. Findings include: On 6/15/11 at 10:00 a.m., the employee records were reviewed and indicated the activity staff member did not have a degree and did not complete an approved course approved by the Indiana	R0329	**R 329 Beardsley House is currently recruiting for a qualified Meaningful Pursuits Coordinator to plan activities and recruit volunteers. No residents were affects by this finding. The Meaningful Pursuits Coordinator, who has completed the approved course, and has been employed for several years, from a sister community will serve as a consultant to the staff member assuming the role. The Regional Director of Quality and Care Management or designee will review the**	07/31/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Department of Health. The activity staff member had been employed since 2/15/10. On 6/15/11 at 10:30 a.m., the activity staff member was interviewed in regard her credentials for an Activity Director, and she indicated she was not currently enrolled in an accredited program and did not have a college degree.		**record of consultation during routine house visits every 30 to 45 days.** **R0329-7/29/11 Addendum** **The activity person from a sister facility who is consulting with the Meaningful Pursuits Coordinator will telephonically discuss the activity calendar, implementation of the activities, volunteer recruitment and answer questions on a weekly basis.**	
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. A. Based on record reviews and interview, the facility failed to ensure the clinical records were organized. This deficiency affected 3 of 7 clinical records that were reviewed in a sample of 7. (Residents #3, #21, #22) B. Based on record review and interview, the facility failed to accurately monitor the documentation of Warfarin (a medication to prevent blood clots) for 1 of	R0349	**R 349** **A.** **Beardsley House will have resident clinical records in a systemically organized manner in individual binders.** **No other residents were affected.** **Beardsley House will review the clinical records of the current residents to ensure**	07/31/2011

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	1 resident receiving Warfarin in a sample of 7. (Resident #22) Findings include: A 1. The record of Resident #21 was reviewed on 6/13/11 at 1:15 p.m., was admitted to the facility on 11/21/09 with diagnoses including, but not limited to, diabetes and hyperlipidemia. The record for Resident #21 was disorganized and the front pocket inside the binder contained 10 pages of Resident's Service Notes and 5 pages of lab results. A 2. The record of Resident #3 was reviewed on 06/13/11 at 10:30 a.m. Resident #3 was admitted to the facility on 07/02/10 with diagnoses including, but not limited to, diabetes, morbid obesity, hypertension, and gout. The record for Resident #3 was disorganized and in disarray to the extent it was difficult to ascertain the current needs of the resident. The record contained numerous loose forms throughout the 3 ring binder/chart, including but not limited to: The inside pocket, front, of the binder: 24 loose pages including, but not limited		**that they are consistently organized. Contents under each tab will be organized according to company policy. Records will be thinned as indicated on that policy.** **The Residence Director and/or licensed nurse will assign a staff member with this task, and train that person as needed.** **The Residence Director will monitor the clinical records monthly x 3 mo, then intermittently, to ensure that the records are organized.** **B.** **Beardsley House will accurately document changes in dosage and administration of medication on the Medication Administration Record.** **A Coumadin flow sheet will be placed in use for those residents who are taking this medication. It will track the dose changes and lab draws.** **The licensed nurse will be responsible for ensuring that the orders are accurately transferred to the Medication Administration Record.**	

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	to: fax transmission forms with physician's orders, monthly physician order sheets, transportation request sheets, lab results, physician consult reports. The inside pocket, back, of the binder: 10 loose pages including, but not limited to, physician consult reports and lab reports. Physician Services tab: 15 loose, unsecured and bent pages of information. Lab/Consults tab: 9 loose, unsecured pages of transportation information, labs, physician orders and physician consult reports. A 3. The records of Resident #22 were reviewed on 06/13/11 at 10:00 a.m.. Resident #22 was admitted to the facility on 11/07/08 with diagnoses including, but not limited to: dementia, hypertension, osteoporosis, recurrent UTI's (urinary tract infections) and anxiety. The record for Resident #22 was disorganized and in disarray to the extent it was difficult to ascertain the current needs of the resident. The record contained numerous loose forms throughout the 3 ring binder/chart, including but not limited to:		**The licensed nurse will review the Medication Administration Record at least once weekly to ensure that medication administration is documented accurately as an ongoing QA process.** **The Regional Director of Quality and Care Management or designee will review the Medication Administration Record during routine house visits every 30 to 45 days.**	

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	The inside pocket of the binder: 2 POA (Power of Attorney) packets of 4 pages each, 1 for Resident #22 and 1 misfiled from another resident's clinical record. Loose progress notes, a CXR (Chest X-Ray) report) a podiatry progress note, a physician's order, and facility communication forms. Physician Services tab: 4 loose physician order sheets. Secured forms were out of order in regards to dates. The 2 page physician order sheets were separated, but secured and out of sequence. Wellness tab: Loose Resident Services notes and family communication forms. Secured forms were out of order in regards to dates. On 6/14/11 at 1:50 p.m., during an interview with the Wellness Director in regard to the clinical records, she indicated had a CNA file in the clinical records for one full day. The Wellness Director indicated what did not fit in the clinical binder was put in the front and she was told by Corporate not to thin the charts. B 1. The clinical record of Resident #3 was reviewed on 06/13/11 at 10:30 a.m.			

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	Resident #3 was admitted to the facility on 07/02/10 with diagnoses including, but not limited to, diabetes, morbid obesity, hypertension, and gout. The WD (Wellness Director: RN) indicated during interview on 06/14/11 at 7:30 a.m., Resident #3 was alert, oriented, and interviewable. Review of the Physician's Order Sheet for 03/2011 thru 06/2011 indicated: "11/17/10 Warfarin Sodium 6 mg tablet: Give 1 tablet orally 1 day a week on Saturdays" "11/17/10 Warfarin Sodium 3 mg tablet: Give 1 tablet orally six days a week (omit Saturdays)" Review of the MARs (Medication Administration Record) for 05/2011 thru 06/2011 indicated the Warfarin 6 mg was administered daily. Review of the most recent PT/INR (Pro-Time/International Ratio: a test to monitor blood clotting time), dated 04//12/11, indicated results within normal limits. Resident #3 was interviewed on 06/14/11 at 10:30 a.m. Resident #3 was aware of her Warfarin dosage and indicated she received the higher dose Warfarin on Saturdays.			

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	The WD was interviewed on 06/14/11 at 11:00 a.m. The WD was unaware the Warfarin dosage was being recorded by staff as administered daily.			
R0406	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on record review, observations, and interviews, the facility failed to ensure and Infection Control program was established and followed to ensure staff were inserviced on infection control and preventative measures were maintained in regards to the care for 1 of 1reviewed who tested positive for Clostridium Difficile (C-diff) in a sample of 7 residents reviewed for infections. (Resident #22) Finding includes:	R0406	**R 406 Beardsley House will implement a system for providing a safe and sanitary environment with prevention of the transmission of infections. No other residents were affected. The staff will be educated regarding infectious conditions and how they are transmitted. In the case of C. Diff, the staff, resident if able to understand, and family will be educated regarding prevention of the spread of this disease process by using proper**	07/31/2011

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	The records of Resident #22 were reviewed on 06/13/11 at 10:00 a.m.. Resident #22 was admitted to the facility on 11/07/08 with diagnoses including, but not limited to: dementia, hypertension, osteoporosis, recurrent UTI's (urinary tract infections) and anxiety. Review of lab results in the chart indicated: "Microbiology Procedure: ...Collected 09/09/10 Source: Feces Final Report: Positive for Clostridium Difficile Antigen Positive for Toxin A/B...Notify Infection Control." There were no other lab reports on feces specimens in the record. Review of Resident Services Notes for Resident #22 indicated the following dated, untimed entries: "08/05/10 Staff reported 3 separate episodes of diarrhea c (with) chronic hx (history) of same r/t (related/to) ATB (antibiotic) use for UTI's (urinary tract infections)." "08/06/10 Called (physician's name) cell requesting order for C-diff culture for stools..."		**handwashing and the use of gloves. The staff will be educated regarding the procedure for cleaning bathrooms, common areas and areas that may become contaminated. Resident #22 had testing for the presence of the C. Diff toxin in her stool. Results showed no presence of infection. It is thought that she may be having a side effect of Aricept, and the attending physician has been notified. The Residence Director will ensure that the licensed nurse provides the required training for staff to address infections that are identified as an ongoing process.** **R0406 and R0407 7/29/11 Addendum** **Staff will be educated regarding Standard Precautions, the guidelines for handwashing, the use of gloves and appropriate housekeeping methods. If an infectious condition is identified, the staff will receive education regarding that particular condition and how to prevent transmission to others**	

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	"08/10/10 ...was + (positive) for C-diff. Flagyl et (and) Urocid Rx (antibiotics) OK'd..." "08/23/10 Resident was found to have bright red, mucousy stools today..." "09/01/10 Spoke c family...resident will eat meals in room c (brand name) underpads and (brand name) liners inside briefs." "09/02/10 ...decision was made yesterday to have resident eat meals in her room r/t dumping syndrome et increase diarrhea when eating in dining room. Explained to daughters (2 names listed) that it was an infection control issue when feces is on chair and floor in public dining room area, but they want resident to remain in dining room for meals. Care plan conference scheduled..." "09/11/10 Resident lab test confirmed positive for clostridium difficile antigen and toxin A/B. Notified WD (Wellness Director: RN)." "09/15/11 10 a.m. Spoke c daughter/POA (Power of Attorney) (name) today residents skin is red and warm to touch-daughter states 'keep her safe and comfortable, no hospital, no Tx (treatment) for infection'..." "09/18/10 Another resident stated this			

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	resident was found in her room late last night attempting to climb into bed with her..." "09/19/10 9:00 a.m. .Explosive diarrhea down legs and onto clothing..." "12/23/10 Resident found sitting in hallway..." "01/11/11 10:00 a.m. Resident found c pans and briefs pulled down and was handling own feces and eating it..." "05/02/11 Resident found wandering in hallway with pants and briefs around ankles, tried to defecate on chair in hallway..." While accompanied by the RD (Resident Director), during the environmental tour, on 06/14/11 between 9:00 and 9:45 a.m., the carpet in the hallway outside of the apartment was noted to have seven areas ranging in dime to half-dollar size of dark unidentifiable matter near a chair. The RD indicated the chair was for anyone's use and the areas on the carpet were from Resident #22 defecating on or near the chair. The RD was uncertain how long the areas had been there. The RD indicated the facility does not have an extractor in working order to address heavily soiled areas. Interview with the WD (Wellness Director: RN) on 06/14/11 at 8:30 a.m. indicated Resident #22 was demented and			

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	incontinent. The WD indicated the family refused to have the resident retested for C-diff. The WD indicated the facility had addressed issues with corporate in regards to the resident defecating in common areas; however the facility was instructed they could not discharge the resident. The WD indicated the facility had identified the Resident #22 was an infection control risk but were unable to provide continued monitoring to prevent the resident from defecating throughout the common areas. The WD was interviewed again, on 06/16/11 at 9:30 a.m., in regards to Infection Control and if the facility had a Policy and Procedure manual or guidelines to refer to. The WD was uncertain but thought the information could be found in the corporate resource guide. The WD indicated no inservices were completed with staff following the diagnosis of C-diff for Resident #22. The WD provided a copy of an infection tracking tool, which included 7 entries for 5 separate residents from 05/13/10 through 08/09/10. The tracking form indicated the following areas for each entry: Resident Name: completed Date of Onset: completed Source of Infection: completed Symptoms Displayed: completed			

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	Treatment (Medications & Duration): completed Preventative Measures: Blank Resolution Date: Blank Review of Inservice Education, provided by the WD on 06/15/11 at 10:00 a.m., indicated an inservice, titled, "INFECTION CONTROL GUIDELINES: STANDARD PRECAUTIONS & ADDITIONAL PRECAUTIONS" was presented on 01/27/11. The inservice covered modes of transmissions and standard precautions. The inservice did not address C-diff or specific methods of cleaning areas of contamination. PSA #2 (Personnel Service Assistant) was interviewed on 06/16/11 at 9:00 a.m. PSA #2 indicated Resident #22 is known to have a long term diagnosis of C-diff with recurring bouts of loose feces. PSA #2 indicated no specific methods of cleaning are used for the apartment or common areas when Resident #22 is incontinent. Employee #8 was interviewed on 06/16/11 at 9:10 a.m. Employee #8 works Monday through Friday, 4 hours a day. Employee #8 is the Activity Director for 2 hours and the only Housekeeper for 2 hours. Employee #8 indicated she received no direction in specific cleaning methods for C-diff.			

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	Review of a corporate Policy and Procedure, titled, "Wellness Resource Guide 8/2009" and provided by the WD on 06/16/11 at 10:00 a.m., indicated: "Management of Infectious Diseases:... 3. A staff in-service should be held when a resident has contracted an infectious disease to provide information regarding the condition, review appropriate infection control procedures, and answer any questions staff members may have." "Specific Disease Management:... Clostridium Difficile...Rigorous cleaning of floors and toilets of infected residents using warm water and detergents is the most effective measure for removing spores from contaminated environments.... Due to the potential spread of infection, residents with C. Difficile should remain in their rooms. Basic precaution to take to prevent the spread of C. Difficile: thorough hand washing between resident contacts, thorough cleaning of all equipment and the environment (all door knobs and common bathrooms should be disinfected at least once a shift), gloves should be worn during incontinence care and laundry should be transported in solid containers."			

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R0407	(b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review, observations, and interviews, the facility failed to ensure staff were inserviced on infection control and preventative measures were maintained in regards to the care for 1 of 7 residents reviewed for infections in a sample of 7 and who was positive for Clostridium Difficile (C-diff). (Resident #22) Finding includes: The records of Resident #22 were reviewed on 06/13/11 at 10:00 a.m. . Resident #22 was admitted to the facility on 11/07/08 with diagnoses including, but not limited to: dementia, hypertension, osteoporosis, recurrent UTI's (urinary tract infections) and anxiety.	R0407	**R407Beardsley House will implement a system for identification, tracking, and educating regarding infections and the procedures to be implemented to prevent transmission. No other residents were affected. The staff will be educated regarding infectious conditions, how they are transmitted, and methods to prevent transmission. In the case of C. Diff, the staff, resident if able to understand, and family will be educated regarding prevention of the spread of this disease process by using proper handwashing, the use of gloves and appropriate cleaning procedures. The staff will be educated regarding the**	07/31/2011

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	Review of lab results in the chart indicated: "Microbiology Procedure: ...Collected 09/09/10 Source: Feces Final Report: Positive for Clostridium Difficile Antigen Positive for Toxin A/B...Notify Infection Control." There were no other lab reports on feces specimens in the record. Review of Resident Services Notes for Resident #22 indicated the following dated, untimed entries: "08/05/10 Staff reported 3 separate episodes of diarrhea c (with) chronic hx (history) of same r/t (related/to) ATB (antibiotic) use for UTI's (urinary tract infections)." "08/06/10 Called (physician's name) cell requesting order for C-diff culture for stools..." "08/10/10 ...was + (positive) for C-diff. Flagyl et (and) Urocid Rx (antibiotics) OK'd..." "08/23/10 Resident was found to have bright red, mucousy stools today..." "09/01/10 Spoke c family...resident will		**procedure for cleaning bathrooms, common areas and areas that may become contaminated. Resident #22 had testing for the presence of the C. Diff toxin in her stool. Results showed no presence of infection. It is thought that she may be having a side effect of Aricept, and the attending physician has been notified. The Residence Director will ensure that the licensed nurse provides the required training for staff to address infections that are identified as an ongoing process. The Infection Tracking Log will be faxed to the Regional Director of Quality and Clinical Services monthly for review of the identified infections and the outcome. R0406 and R0407 7/29/11 Addendum** **Staff will be educated regarding Standard Precautions, the guidelines for handwashing, the use of gloves and appropriate housekeeping methods. If an infectious condition is identified, the staff will receive education regarding that particular condition and how to prevent transmission to others.**	

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	eat meals in room c (brand name) underpads and (brand name) liners inside briefs." "09/02/10 ...decision was made yesterday to have resident eat meals in her room r/t dumping syndrome et increase diarrhea when eating in dining room. Explained to daughters (2 names listed) that it was an infection control issue when feces is on chair and floor in public dining room area, but they want resident to remain in dining room for meals. Care plan conference scheduled..." "09/11/10 Resident lab test confirmed positive for clostridium difficile antigen and toxin A/B. Notified WD (Wellness Director: RN)." "09/15/11 10 a.m. Spoke c daughter/POA (Power of Attorney) (name) today residents skin is red and warm to touch-daughter states 'keep her safe and comfortable, no hospital, no Tx (treatment) for infection'..." "09/18/10 Another resident stated this resident was found in her room late last night attempting to climb into bed with her..." "09/19/10 9:00 a.m. .Explosive diarrhea down legs and onto clothing..." "12/23/10 Resident found sitting in hallway..." "01/11/11 10:00 a.m. Resident found c			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEARDSLEY HOUSE	27833 CR 24 ELKHART, IN46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pans and briefs pulled down and was handling own feces and eating it..." "05/02/11 Resident found wandering in hallway with pants and briefs around ankles, tried to defecate on chair in hallway..." Resident #22 was observed each day of the survey and included, but were not limited to: Resident #22 was observed on 06/13/11 at 10:30 a.m. wandering aimlessly throughout the hallway and main lounge area of the facility. Resident #22 was observed on 06/14/11 at 9:00 a.m., while accompanied by the RD (Resident Director) with her apartment door opened and lying atop her sofa. The carpet in the hallway outside of apartment was observed to have seven areas ranging in dime to half-dollar size of dark unidentifiable matter near a chair. The RD indicated the chair was for anyone's use and the areas on the carpet were from Resident #22 defecating. The RD was uncertain how long the areas had been there. The RD indicated the facility does not have an extractor in working order to address heavily soiled areas. Resident #22 was observed on 06/15/11 at 11:00 a.m. wandering aimlessly throughout the common areas.			

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	Resident #22 was observed on 06/16/11 at 10:30 a.m. wandering in the activity area during an activity, expressing a need to toilet. Interview with the WD (Wellness Director: RN) on 06/14/11 at 8:30 a.m. indicated Resident #22 was demented and incontinent. The WD indicated the family refused to have the resident retested for C-diff. The WD indicated the facility had addressed issues with corporate in regards to the resident defecating in common areas; however the facility was instructed they could not discharge the resident. The WD was interviewed again, on 06/16/11 at 9:30 a.m., in regards to Infection Control. The WD indicated no inservices were completed with staff following the diagnosis of C-diff for Resident #22. Review of Inservice Education, provided by the WD on 06/15/11 at 10:00 a.m., indicated an inservice, titled, "INFECTION CONTROL GUIDELINES: STANDARD PRECAUTIONS & ADDITIONAL PRECAUTIONS" was presented on 01/27/11. The inservice covered modes of transmissions and standard precautions. The inservice did not address C-diff or specific methods of cleaning areas of contamination.			

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	PSA #2 (Personnel Service Assistant) was interviewed on 06/16/11 at 9:00 a.m. PSA #2 indicated Resident #22 is known to have a long term diagnosis of C-diff with recurring bouts of loose feces. PSA #2 indicated no specific methods of cleaning are used for the apartment or common areas when Resident #22 is incontinent. Employee #8 was interviewed on 06/16/11 at 9:10 a.m. Employee #8 works Monday through Friday, 4 hours a day. Employee #8 is the Activity Director for 2 hours and the only Housekeeper for 2 hours. Employee #8 indicated she received no direction in specific cleaning methods for C-diff. Review of a corporate Policy and Procedure, titled, "Wellness Resource Guide 8/2009" and provided by the WD on 06/16/11 at 10:00 a.m., indicated: "Management of Infectious Diseases:... 3. A staff in-service should be held when a resident has contracted an infectious disease to provide information regarding the condition, review appropriate infection control procedures, and answer any questions staff members may have." "Specific Disease Management:... Clostridium Difficile...Rigorous cleaning of floors and toilets of infected residents using warm water and detergents is the			

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	most effective measure for removing spores from contaminated environments.... Due to the potential spread of infection, residents with C. Difficile should remain in their rooms. Basic precaution to take to prevent the spread of C. Difficile: thorough hand washing between resident contacts, thorough cleaning of all equipment and the environment (all door knobs and common bathrooms should be disinfected at least once a shift), gloves should be worn during incontinence care and laundry should be transported in solid containers."			
R0408	(c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interviews and record review, the facility failed to ensure a resident had received a chest X-ray admission. This deficiency affected 1 resident who had not received an admission chest X-ray in a sample of 7 (Resident # 19). Finding include: The clinical record of Resident #19 was reviewed on 6/13/11 at 10:30 a.m., and indicated an admission date of 4/15/11. The Radiology report dated 4/26/11	R0408	**R 408** **Resident #19 has a chest x-ray in place.** **No other residents were affected.** **Beardsley House has an admission process in place that includes providing documentation of a chest x-ray completed in the past 6 months. It is the responsibility of the Residence Director to**	07/31/2011

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	indicated the resident had a chest X-ray done. The fax sheet dated 4/26/11 indicated the Physician had been contacted and had ordered an admission chest X-ray. On 6/14/11 at 11:30 a.m., the Wellness Director was interviewed in regard to the facility had not obtained an admission chest X-ray. The Wellness Director indicated it was the responsibility of the Resident's Sales Manager to make sure the admission chest X-ray was done. On 6/16/11 at 9:30 a.m., the Resident's Sales Manager was interviewed in regard to the resident's admission chest X-ray did not get done and indicated she was on a leave of absence at the time the resident was admitted to the facility. The Resident's Sales Manager indicated the Community Sales Specialist was responsible to make sure the resident had received a chest X-ray on admission and she is unsure why this got missed. On 6/16/11 at 10:30 a.m., the undated policy for "TB (tuberculosis) TESTING FOR RESIDENTS" was received from the Wellness Director who indicated this was the most current policy and indicated "1. All residents must have a diagnostic chest x-ray completed no more than six		**ensure that the admission paperwork is in place prior to move in.** **The Regional Director of Quality and Care Management will review new admission paperwork as part of a routine house visit every 30-45 days to ensure that admission chest x-rays are in place.**	

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	(6) months prior to admission."			